In this way one can, as a rule, readily differentiate between normal, insufficient, and stenotic valves. Weighing the ventricles separately, according to the method of Müller is also of great aid, and in combined mitral lesions the weights of the ventricles and the closure test allow of closer analysis than has heretofore been possible. The closure test has revealed a surprising number of cases of pure mitral stenosis. Schabert concludes: (1) The closure test is satisfactory in the great majority of cases examined, and permits of far more certain decision as to the presence of stenosis or insufficiency than the usual inspection of the valves. (2) The results of the closure test should be controlled by weighing the ventricles separately. (3) Cases of pure stenosis are only recognizable by the closure test. (4) In pure mitral insufficiency an hypertrophy of the left ventricle is always present.

Myeloid Chloroma.—JACOBAEUS (*Deutsch. Arch. f. klin. Med.*, 1909, xcvi, 7) reports two new cases of myeloid chloroma or chloroleukemia, as Naegeli calls the disease. This brings the total number of myeloid chloromas to ten since Turk's original case in 1903. In both of Jacobbaeus' cases myelocytes and myeloblasts were conspicuous in the blood picture. The diagnosis was made antemortem in the first case by the greenish skin metastases, in the second by blood examination; 5 c.c. of blood was treated with citrate and centrifugalized. The resulting layer of leukocytes had a faint greenish tint. Controls from six normal individuals and chronic myeloid leukemias, which were examined similarly, showed no trace of green in the leukocyte layer. Thus, for the first time, examination of the blood alone has led to the correct diagnosis of chloroma, as the postmortem finding subsequently proved.

SURGERY.

UNDER THE CHARGE OF

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The Bone Fragility and Eburnation of Rachitis.—BLANCHARD (*Amer. Jour. Orthop. Surg.*, 1909, vi, 616) says that normal bone ossifies slowly. Normal unossified bone bends under the pressure of the osteoclast. Rachitic bone may remain friable indefinitely, but with favoring conditions eburnates suddenly. Eburnated bone breaks hard, and is not amenable to any pressure of iron braces or a plaster of Paris. Very mild bow-leg that is not at all or only slightly rachitic may be autocorrected. Rachitic bow-leg, knock-knee, and anterior bent tibia are never autocorrecting and frequently grow worse in bed. Badly deforming, rachitic knock-knee and bow-leg are occasionally seen in children that have never walked. Rachitic bow-leg predisposes to rachitic coxa vara. Rachitic knock-knee predisposes to rachitic coxa valga. Knock-knee is distributed distortion of all the long bones of the legs, having its usual inception in an inbend of the upper tibial shaft. Bow-leg is a distributed distortion of all the long bones of the leg, having its usual inception in an outbend of the femoral shaft, though, as the deformity progresses, the secondary outbend of the tibia frequently becomes the most pronounced. The skiagraphic observations of a large number of cases would seem to prove quite conclusively that these deformities closely follow fixed lines of development. Rapid osteoclasis is the safest and quickest means of correcting most of the rachitic deformities of the legs. The term rapid osteoclasis is used because osteoclasis that is not rapid is always a failure and brings the osteoclast into disrepute. These conclusions are drawn from nearly 1000 cases of knock-knees, bow-legs, and anterior bent tibiæ corrected by rapid osteoclasis with the Grattan osteoclast.

A New Method of Treating Hydrocele.—MARCOZZI (*Ann. d. mal. org. gén.-urin.*, 1909, i, 739) says that the tunica vaginalis is important for the function of the testicle. A certain number of hydroceles, especially those of recent origin, show only slight distention and thickening of the tunic, and for this reason have a tendency to cure. In such cases it would be best to try first some non-operative treatment, such as the injection into the sac of some suitable medicament, like iodine or silver nitrate. It does not always cure, but is frequently followed by recurrence. This is probably due to the fact that the effect of the injected substance is too fleeting to permit it to act long enough upon the chronically inflamed serous sac. Marcozzi has employed in 10 cases an injection of fragmented magnesium thread. This is first washed in ether and then sterilized in distilled water. After being injected it is easily absorbed and produces a durable stimulation and reaction of the serous surfaces. As the result of his success in the use of this method, he concludes that it is more advantageous than all others. It produces no pain and permits the patient to continue at his usual occupation. There is no risk of necrosis of the scrotal tissues, such as has followed the employment of the tincture of iodine.

Partial Sequestration of a Transplanted Piece of Bone.—AXHAUSEN (*Arch. f. klin. Chir.*, 1909, lxxxix, 281) resected the upper end of the humerus and the joint capsule for a secondary cancer in this situation, which had followed an operation for the removal of a cancer of the breast, two and one-half years before. There was no recurrence in the scar or in the lymph glands. After removal of the upper end of the humerus, the second, right metatarsal bone was extirpated and its attached muscles carefully removed. Then several incisions were made through its periosteum and its proximal end was freshened and pointed. Its pointed end was then driven into the medullary cavity of the upper end of the divided humerus. The two attached bones were then replaced so that the cartilaginous surface of the metatarsal bone fitted into the glenoid cavity of the scapula. The muscles, which had been detached from the humerus, were sutured to the periosteum of the upper divided